NAME _____

DATE OF BIRTH ____/____/____

SOCIAL SECURITY NUMBER _____-____-_____

MEDICAL EXPENSES

FORM - SIDE 1

Doctor/Facility Or Prescription	Date(s) of Service	Amount $	Sent to Ins by Doctor √	You √	Date sent to 2nd Insurance	Comments	Amt. Paid by Insurance	Amt. Paid by 2nd Insurance	Date of Payment	Amt. Paid by Self	Check # Charge # Account

NAME _____

DATE OF BIRTH ____/____/____

SOCIAL SECURITY NUMBER _____-____-_____

MEDICARE EXPENSES

FORM - SIDE 2

Doctor/Facility Or Prescription	Date(s) of Service	Amount $	Sent to Medicare by Doctor √	Sent to Medicare by You √	Date sent to Supplemental	Comments	Amt. Paid by Medicare	Amt. Paid by Supplemental	Date of Payment	Amt. Paid by Self	Check # Charge # Account